United States Department of Labor
Employees' Compensation Appeals Board

NANCY J. PINNA (FRANK M. PINNA),	)	
Appellant	)	
	)	**Docket No. 04-97**
and	)	**Issued: June 3, 2004**
	)	
DEPARTMENT OF THE TREASURY,	)	
INTERNAL REVENUE SERVICE,	)	
Phoenix, AZ, Employer	)	

Appearances:
Steven E. Brown, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Member
DAVID S. GERSON, Alternate Member
WILLIE T.C. THOMAS, Alternate Member

JURISDICTION

On October 17, 2003 appellant filed a timely appeal from an Office of Workers' Compensation Programs' decision dated October 18, 2002, denying her claim for death benefits. Pursuant to 20 C.F.R.[1] §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether the employee's death was causally related to his accepted employment injury.

[1] The Code of Federal Regulations.

FACTUAL HISTORY

On December 28, 1976 the employee, then a 49-year-old special agent, filed an occupational disease claim alleging that he developed a heart condition causally related to job stress. The Office accepted the employee's claim for a progressive heart block with idioventricular arrhythmias secondary to Lenegre's disease, aggravated by his employment. The employee received a pacemaker for his heart condition in November 1976. He died on April 1, 2002. The death certificate listed the immediate cause of death as cardiac arrest due to cardiomyopathy as a result of coronary artery disease. On April 25, 2002 appellant filed a claim for death benefits.

In an attending physician's report dated December 24, 1976, Dr. Eugene L. Schwartz, a Board-certified internist specializing in cardiovascular disease, diagnosed a progressive conduction defect due to Lenegre's disease and accelerated idioventricular rhythm induced by stress. He noted that on November 23, 1976 the employee received a permanent transvenous pacemaker for his heart. In answer to the question regarding anticipated permanent effects of the condition, Dr. Schwartz indicated, "[t]he ventricular beats, if uncontrolled, have a potential for inducing fatal cardiac arrhythmia." He determined that the employee was totally disabled and would require medication to control his heart rhythm and a pacemaker for the rest of his life.

In an April 5, 1977 report, Dr. Schwartz stated that, when he examined the employee in 1976 he found that he had bifascicular heart block with intermittent episodes of trifascicular heart block and episodes of symptomatic bradycardia-induced accelerated idioventricular rhythm. He stated that he originally thought a pacemaker would take care of the heart block episodes and, by insuring that bradycardia did not develop, might prevent the accelerated idioventricular rhythm from developing. Dr. Schwartz noted that the employee continued to have runs of accelerated idioventricular rhythm despite the pacemaker and was placed on medication.

In reports dated April 29, 1981 to May 7, 1990, Dr. Schwartz addressed his treatment of appellant for continued stress-related Lenegre's disease, cardiac arrhythmia, ventricular arrhythmia, premature ventricular contractions, atrial flutter, atrial fibrillation, congestive heart failure, ventricular tachycardia and trifascicular heart block with permanent pacemaker dependency.

On August 10 and 12, 1992 Dr. Jon R. Hillegas, a Board-certified surgeon, indicated that the employee had Lenegre's disease with heart block, premature ventricular contractions, supraventicular tachycardia and atrial flutter and had received a new pacemaker.

In a January 31, 1994 report, Dr. William V. Gaul, a Board-certified internist specializing in cardiovascular disease, found normal coronary arteries but stated that the employee appeared to have dense ventricular dysfunction.

In reports dated January 25, 1994 through February 12, 1997, Dr. Gaul diagnosed idiopathic dilated congestive cardiomyopathy, atrial septic defect, chronic atrial fibrillation, a

complete heart block secondary to Lenegre's disease, left atrial enlargement and left ventricular dysfunction with congestive heart failure.

In a report dated March 31, 1997, Dr. Kenneth Schaefer, an internist, stated that the employee had multiple heart problems including fibrillation, atrial septal defect, severe left ventricular dysfunction with less than a 10 percent and coronary artery disease with angina. On February 29, 2000 Dr. Gaul stated that the employee was seen for follow up of his congestive cardiomyopathy, atrial septal defect and chronic atrial fibrillation. He indicated that the employee was doing reasonably well.

On January 23, 2001 Dr. Gaul noted the employee's conditions of chronic atrial fibrillation, atrial septal defect and left ventricular dysfunction and indicated that he had no signs of heart failure.

On January 15, 2002 Dr. Gaul diagnosed severe end-stage left ventricular dysfunction with minimal coronary artery disease, chronic atrial fibrillation and atrial septal defect.

In a report dated April 16, 2002, subsequent to the employee's death on April 1, 2002 Dr. Gaul stated that he had treated the employee for at least 15 years for severe left ventricular dysfunction with ejection fraction of approximately 10 percent, an atrial septal defect and chronic atrial fibrillation. He stated that the employee "has been chronically disabled by his severe left ventricular dysfunction since 1976."[2]

The Office prepared a statement of accepted facts dated June 6, 2002 in which it stated that the employee received a pacemaker in 1976 that was replaced in 1979 and he had the work-related condition of "progressive heart block with idioventricular arrhythmias (symptomatic) secondary to Lenegre's disease aggravated by his employment." The statement of accepted facts indicated that the employee had a preexisting condition of "progressive conduction defect due to Lenegre's disease (idiopathic fibrosis)."

In a June 21, 2002 report, Dr. Ajit Raisinghani, a Board-certified internist specializing in cardiovascular disease and internist and an Office medical adviser, provided a history of the employee's condition and a review of the medical records. He stated:

> "[Appellant's] echocardiogram from January 1994 was significantly different from the echocardiogram which was done earlier in 1992, in which he did not have any major abnormalities in his LV [left ventricular] function. [The employee] was subsequently managed medically since 1994 for his LV dysfunction and A-FIB [atrial fibrillation]."
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> "Regarding the question [of] whether the cause of death [was] precipitated, accelerated or proximately caused by the factors of employment as described in the [s]tatement of [a]ccepted [f]acts, it is my belief that the [employee's] cause of

[2] Dr. Gaul was the physician who signed the employee's death certificate.

death was most likely related to his severe LV dysfunction with an ejection fraction of 10 percent. There is a fair amount of data to say that most deaths in this group of patients with idiopathic dilated cardiomyopathy are related to ventricular arrhythmias and are most likely the cause of death in these groups of patients.

"Therefore, it appears that the [employee's] history of progressive heart block secondary to Lenegre's disease is unrelated to [his] cause of death. Furthermore, the [employee's] cardiomyopathy did not develop until 1994 or at least was diagnosed at that time, which was approximately 18 years after his initial diagnosis of heart block, which was the reason for his disability.

"It has been 18 years since he went on disability.

"Therefore, I do not believe that the cause of death was precipitated, accelerated or proximately caused by the factors of employment 18 years prior."

The Office requested clarification from Dr. Raisinghani regarding the issue of whether the employee's work-related condition contributed to his death. The Office stated:

"Your report noted a history of several episodes of *atrial* arrhythmias, yet *idioventricular* arrhythmias are accepted as work related. Please explain the difference in these types of arrhythmias and between ventricular and idioventricular arrhythmias.

"Page three of your report states that you believed that [the employee's] cause of death was 'most likely related to his severe LV dysfunction with an [ejection fraction] of 10 percent.' You also find that his history of progressive heart block secondary to Lenegre's disease is unrelated to the cause of death. The accepted work-related condition included heart block *with idioventricular arrhythmias* secondary to Lenegre's disease; you stated that 'most deaths in this group of patients with idiopathic dilated cardiomyopathy are related to ventricular arrhythmias and are most likely the cause of death in these groups.'

"Treating cardiologist, William Gaul, stated on [April, 16, 2002] … that [the employee] had been chronically disabled by *severe left ventricular dysfunction since 1976*. However, you found that the cardiomyopathy did not begin until the 1990's.

"Please account for the above points in providing your medically reasoned clarification as to whether the work-related condition contributed to [the employee's] death, to include comment on Dr. Gaul's statement noted above." (Emphasis in the original.)

In a supplemental report dated August 13, 2002, Dr. Raisinghani stated:

> "Although Dr. Gaul states that [the employee] has been chronically disabled secondary to left ventricular dysfunction since 1976, I am unable to find any evidence to support this. In fact, based on the medical records submitted [the employee] had normal left ventricular function as documented by an echocardiogram done in 1992. This was a significant change from the echocardiogram done in 1994, in which an ejection fraction of 10 percent was first documented.
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> "[The employee] had accepted work-related condition of heart block with idioventricular arrhythmia. [He] in addition had episodes of atrial flutter and atrial fibrillation. In general cardiac arrhythmias are diagnosed and named depending on where from the heart they originate. Atrial rhythm would originate from the atria and ventricular rhythm from one of the ventricles of the heart. Idioventricular rhythms are thought to originate from the ventricles; however, since they are often slower than traditional ventricular arrhythmias they are given a specific name. In general these rhythms do not require specific treatment.
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> "To summarize, [the employee] had several different rhythms that existed throughout the course of his life. In addition, what I would consider most significant was his diagnosis of cardiomyopathy with an ejection fraction of 10 percent, first diagnosed by an echocardiogram in 1994, when he presented with recurrence of atrial fibrillation and congestive heart failure."

By decision dated October 18, 2002, the Office denied appellant's claim for death benefits on the grounds that the weight of the medical evidence was represented by the opinion of Dr. Raisinghani and established that the employee's work-related heart condition did not contribute to his death.

LEGAL PRECEDENT

In a claim for death benefits under the Federal Employees' Compensation Act, the claimant for benefits has the burden of proof to establish the necessary elements of his or her claim.[3] The claimant must prove by the weight of the reliable, probative and substantial evidence that the employee's death was causally related to his employment.[4] This burden includes the necessity of furnishing medical opinion evidence, based on a complete factual and

[3] *Judith L. Albert (Charles P. Albert)*, 47 ECAB (1996); *Darlene Menke (James G. Menke, Sr.)*, 43 ECAB 173 (1991).

[4] *Lois E. Culver (Clair L. Culver)*, 53 ECAB ___ (Docket No. 01-640, issued March 5, 2002); *Martha A. Whitson (Joe E. Whitson)*, 43 ECAB 1176 (1992).

medical background, showing causal relationship.[5] The opinion of the physician must be one of reasonable medical certainty and must be supported by medical rationale.[6]

ANALYSIS

The Board finds that this case is not in posture for a decision. Further development of the medical evidence is required. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence.[7]

In a report dated April 16, 2002, subsequent to the employee's death on April 1, 2002, Dr. Gaul stated that the employee "has been chronically disabled by his severe left ventricular dysfunction since 1976." However, he did not provide a rationalized opinion explaining how the employee's accepted heart conditions caused or contributed to his death. Therefore, his report is not sufficient to establish that the employee's death was causally related to his accepted employment injury. Although the reports of Dr. Gaul would not be sufficient to create a conflict with a well-rationalized medical opinion based on a complete and accurate factual background, on the issue of causal relationship, Dr. Raisinghani's reports are not of such caliber.

The Office determined that the reports of Dr. Raisinghani, the Office medical adviser represented the weight of the medical evidence and established that the employee's death on April 1, 2002 was not causally related to his accepted employment injury. However, Dr. Raisinghani's reports do not resolve the issue of causal relationship due to several deficiencies. The employee's claim had been accepted by the Office for a progressive heart block with idioventricular arrhythmias. Dr. Raisinghani stated that the employee's death was due to his severe left ventricular dysfunction with an ejection fraction of 10 percent and opined that most deaths from idiopathic cardiomyopathy were related to ventricular arrhythmias and the employee's ventricular arrhythmia began in 1994. However, the medical evidence contains numerous diagnoses of ventricular and other arrhythmias from 1976 forward from several physicians. Medical reports discuss the employee's cardiac arrhythmia, ventricular arrhythmia, accelerated idioventricular rhythm, premature ventricular contractions, atrial flutter and atrial fibrillation. Furthermore, Dr. Raisinghani did not address the issue of whether the employee's accepted medical conditions contributed in any way to his death, even though the Office specifically asked him to address this issue in its letter requesting clarification of his first report.

CONCLUSION

This case is not in posture for a decision and requires further medical development. On remand the Office should refer the case, including the case file and a statement of accepted facts, to an appropriate medical specialist for a rationalized opinion on the issue of whether the employee's death on April 1, 2002 was causally related to his accepted employment injury.

[5] *Martha A. Whitson (Joe E. Whitson)*, *supra* note 4.

[6] *Kathy Marshall (Dennis Marshall)*, 45 ECAB 827 (1994).

[7] *Udella Billups*, 41 ECAB 260 (1989).

After such further development as the Office deems necessary, the Office should issue an appropriate decision regarding appellant's claim.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated October 18, 2002 is set aside and the case is remanded for further action consistent with this decision.

Issued: June 3, 2004
Washington, DC

Colleen Duffy Kiko
Member

David S. Gerson
Alternate Member

Willie T.C. Thomas
Alternate Member